

Stephen L. Mikochik

General Assembly of the State of Connecticut
House of Representatives
Committee on Public Health
February Session, 2014

Re: R.B. 5326; Testimony of Stephen L. Mikochik

My name is Stephen L. Mikochik.¹ I am professor emeritus of Constitutional Law at Temple Law School in Philadelphia and visiting professor of Jurisprudence at Ave Maria Law School in Florida. I testify today on behalf of the Family Institute of Connecticut against Raised Bill 5326 which, in legalizing assisted suicide, is an open invitation to patient abuse.

For over seven hundred years, Anglo-American law has condemned suicide.² Self-murder was a felony at common law; but, since the deceased was beyond penalty, his property was forfeited as a deterrent to others.³ Recognizing the harm this caused innocent families, English and American law gradually decriminalized suicide.⁴ This development, however, did not mark the moral acceptance of suicide, since aiding its commission remained a common law offense.⁵ At the close of the Civil War, most states criminalized assisting a suicide.⁶ Many states subsequently reaffirmed this ban. By 1997, when the Supreme Court rejected the claim that physician assisted suicide was a constitutional right,⁷ the vast majority of states made it criminal.⁸

Nevertheless, assisted suicide has recently become controversial and, spearheaded by Compassion and Choices, the successor to the Hemlock Society, has a foothold in American law. By ballot initiative in 1994, Oregon became the first state to allow physician assisted suicide.⁹ Its so-called “Death with Dignity Act” set the pattern for the successful 2008 ballot initiative in Washington State.¹⁰ The Vermont legislature adopted its own version this past May,¹¹ while the Montana Supreme Court held in 2009 that physician assisted suicide was not against that state’s

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² *Washington v. Glucksberg*, 521 U.S. 702, 711 (1997).

³ *Id.* at 711-13.

⁴ *Id.* at 713.

⁵ *Id.* at 713-14.

⁶ *Id.* at 715.

⁷ *Id.* at 735.

⁸ *Id.* at 718.

⁹ See O.R.S. § 127.800 *et seq.*

¹⁰ See Wash. Rev. Code Ann. § 70.245.010 *et seq.* (West 2009).

¹¹ See 18 V.S.A. § 5281 *et seq.*

public policy.¹² All other attempts to legalize assisted suicide, either by ballot initiative or legislative enactment, have failed. On March 6, for example, The New Hampshire House of Representatives defeated H.B. 1325 by a vote of 219 to 66.¹³

Before turning to the specifics of R.B. 5326, I will address three threshold questions. First, how can laws that require consent constitute government decisions about life and death? Americans hold as self-evident that all men are “endowed by their Creator with certain unalienable rights; that among these [is the right to] life ... ; [and] that, to secure these rights, governments are instituted among men[.]”¹⁴ As life is an unalienable right, we can neither destroy our lives nor ask others to assist in their destruction.¹⁵ When government secures such rights for some but not others, when it relaxes laws against aiding the suicide of terminal patients but not the able-bodied, it is saying this class deserves less protection against homicide, its members deserve less safeguard of their unalienable rights, in other words, they deserve less respect because in some way they are less human. In discounting rights entrusted to its care, government thus compromises the very grounds on which it was instituted.

Second, why should the disabled community in particular concern itself with laws legalizing assisted suicide that, on their face, are limited to terminal patients? As physical impairments that substantially limit life activities,¹⁶ terminal conditions are disabilities. Thus, to provide, as does R.B. 5326, that a patient is not qualified for assistance in suicide “solely” because of a disability¹⁷ is simply incoherent. Moreover, predictions of death within six months required for aid in dying¹⁸ are notoriously fallible. Thus, even if terminal and disabling conditions are different, the separating line is porous. Further, the primary reasons terminal patients give for requesting aid in dying—loss of autonomy, loss of dignity, inability to

¹² See *Baxter v. Montana*, 354 Mont. 234. Additionally, An Albuquerque district judge this January barred prosecution of physicians for assisting the suicide of terminal patients. See James Monteleone, *Death Aid Case Appeal Possible*, ALBUQUERQUE JOURNAL, Jan. 24, 2014, available at: <http://www.abqjournal.com/342190/news/attorney-general-might-appeal-ruling-on-assisted-suicide.html>. The New Mexico Attorney General, however, appealed that ruling on March 12th. See Alex Schadenberg, Attorney General Appeals Court Ruling to Legalize Assisted Suicide, Life News, Mar. 12, 2014, available at <http://www.lifenews.com/2014/03/12/new-mexico-attorney-general-appeals-court-ruling-to-legalize-assisted-suicide.html>.

¹³ See *Death with Dignity Act' finds little support in NH House*, UNION LEADER, (March 06, 2014, 8:30PM), available at <http://www.unionleader.com/article/20140306/NEWS0621/140309414>.

¹⁴ THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).

¹⁵ JOHN LOCKE, THE SECOND TREATISE OF GOVERNMENT, Ch. IV, §23, available at <http://www.constitution.org/jl/2ndtr04.htm> (“For a man, not having the power of his own life, cannot, by compact, or his own consent, enslave himself to any one, nor put himself under the absolute, arbitrary power of another, to take away his life, when he pleases. No body [sic] can give more power than he has himself; and he that cannot take away his own life, cannot give another power over it.”)

¹⁶ See, e.g., 42 U.S.C. §§12102(1)(A) (Americans with Disabilities Act).

¹⁷ See R.B. 5326, § 2(b).

¹⁸ See *id.* at §1(19).

participate in activities that make life enjoyable¹⁹ — are the same reasons disabled people seek suicide.²⁰ If people with only six months to live can end such distress, why not those who face it for a lifetime?²¹

Third, why should people who respect the conscientious scruples of others oppose R.B. 5326? Despite any moral opposition to suicide, those operating residential institutions and all other landlords, even those living on the premises, cannot evict residents who wish to end their lives by ingesting a lethal prescription.²² Further, though health care facilities (but not assisted living services agencies)²³ can prohibit their employees or physicians with hospital privileges from participating in R.B. 5328 in the course of their employment or contracts,²⁴ “participation” does not include referral to a willing physician²⁵ (which, for many, would constitute formal cooperation with suicide) or agreeing to write the lethal prescription on their own time²⁶ (which could confuse the public about the health care facilities’ own stance on suicide).

Turning to the specifics of R.B. 5326, its language tracks the provisions of, and thus shares the major flaws in, the assisted suicide laws enacted by Oregon and Washington State.²⁷

¹⁹ See REP. OF ORE. PUBLIC HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT--2013, *available at* <https://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year16.pdf>. This report states that “[l]osing autonomy” was given as an end of life concern in 91.4% of cases; “[l]oss of dignity” in 80.9% of cases; and, “[l]ess able to engage in activities making life enjoyable” in 88.9% of cases. Surprisingly, fear of protracted pain was not a major reason given for requesting a lethal prescription, with “[i]nadequate pain control or concern about it” given as an end of life worry in only 23.7% of total cases. See also WASH. DEPT. PUBLIC HEALTH, 2012 DEATH WITH DIGNITY ACT REPORT, *available at* <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2012.pdf>.

²⁰ Cf. Diane Coleman, Editorial, *State’s Rights Versus Civil Rights*, SEATTLE POST-INTELLIGENCER, Sept. 29, 2005, *available at* <http://www.seattlepi.com/local/opinion/article/States-rights-versus-civil-rights-1183888.php>.

²¹ See, e.g., *Assisted Suicide in the United States: Hearing Before the Subcomm. on the Constitution of the Comm. on the Judiciary House of Representatives*, 104th Cong 127-38 (1996) (prepared testimony of Herbert Hendin, M.D.) During his testimony, Dr. Hendin stated:

Over the past two decades, the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical help i.e. euthanasia to those who could not affect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination.

²² See R.B. 5326, §13(d)(2).

²³ Section 1(8) defines “health care facility” to include “a hospital, residential care home, nursing home or rest home, as such terms are defined in section 19a-490 [(b) & (c)] of the general statutes” which in turn defines “assisted living services agency” separately. See C.G.S. §19-490(l).

²⁴ See R.B. 5326, §14(d).

²⁵ See *id.* at §14(a)(4) & (d)(4).

²⁶ See *id.* at §14(d)(6).

²⁷ One difference is that R.B. 5326 requires patients to make two successive written requests for a lethal prescription, *see id.* at §2, while Oregon and Washington both require three (one written and two oral) requests. See O.R.S. § 127.840; *see* Wash. Rev. Code Ann. § 70.245.090 (West 2009). Only upon the first written request, however, does R.B. 5326 require the attending physician to determine whether the patient is competent. See RB 5326, §6(1)(D).

Though it imposes a waiting period before the prescription is written, patients can have a lethal drug in hand fifteen days after the terminal diagnosis is made,²⁸ clearly insufficient time to acclimate to a terminal prognosis.²⁹ A second physician, not excluding a member of the attending physician's practice, must confirm the initial diagnosis, prognosis, and competence of the patient.³⁰ Though either attending or consulting physician can refer patients for psychological or psychiatric evaluation if they suspect clinical depression,³¹ many physicians lack training to recognize such conditions;³² and nothing in R.B. 5326 requires that they have such training. Not surprisingly, referrals were almost never made in the fifteen year history of the Oregon Act and, thus far, Washington is following suit.³³

Given that the Supreme Court has reported that many people, terminal or not, seeking suicide suffer from clinical depression and often lose the urge when the condition is treated,³⁴ the absence of reported referrals in these states is most troubling for the future of R.B. 5326.

The raised bill allows persons with a financial interest in the patient's estate to be one of the two witnesses to both written requests, attesting to the patient's competency and the lack of coercion.³⁵ Though patients can revoke their request "in any manner[.]"³⁶ *including "communicating through a person familiar with the patient's manner of communicating[.]"*³⁷ nothing prevents the interested witness to the patient's written request from filling that role. That same person can be the only witness present when the lethal drug is taken since R.B. 5326 fails

²⁸ See *id.* at Sec. 3(a); Sec. 9(a)(6)(A).

²⁹ Unlike Washington's act, see Wash. Rev. Code Ann. § 70.245.040(1)(i)(ii)(B), however, R.B. 5326 does not specifically prohibit delivery of the legal dose by mail, with the attendant risk of accidental interception by young family members.

³⁰ See R.B. 5326, § 7.

³¹ See *id.* at § 8(a).

³² Cf. *Washington v. Glucksberg*, 521 U.S. at 730-31 ("[A] New York [blue-ribbon] [t]ask [f]orce, however, expressed its concern that, because depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients' needs.") (citations omitted).

³³ For example, of the 71 Oregon residents who died from a lethal prescription in 2013, only two had been referred for a psychiatric or psychological evaluation. See OREGON'S DEATH WITH DIGNITY ACT—2013, *supra* note 9. Oregon's yearly reports from 1998 through 2012 reveal similar statistics; showing: 2 out of 77 in 2012; 1 out of 71 in 2011; 1 out of 65 in 2010; 0 out of 59 in 2009; 2 out of 60 in 2008; 0 out of 49 in 2007; 2 out of 46 in 2006; 2 out of 38 in 2005; 2 out of 37 in 2004; 2 out of 42 in 2003; 5 out of 38 in 2002; 3 out of 21 in 2001; 5 out of 27 in 2000; 10 out of 27 in 1999; and 4 out of 21 in 1998 were referred for evaluations. Similarly, in Washington, of the 121 residents for whom lethal drugs were dispensed in 2012, only 3 had been referred for such evaluation. See 2012 DEATH WITH DIGNITY ACT REPORT, *supra* note 9. Washington's yearly reports from 2011 through 2009 show: 5 out of 103 in 2011; 3 out of 87 in 2010; and 3 out of 63 in 2009 were referred for evaluations.

³⁴ See *Glucksberg*, 521 U.S. at 730-31 ("Research indicates... that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated.") (citations omitted).

³⁵ See R.B. 5326, § 3 (a) & (b)(2). Section 3(d) provides that, "[i]f the patient is a resident of a residential care home, nursing home or rest home, ... one of the witnesses shall be a person designated by such home." (emphasis added). Where the designee is not legally connected to the home—the owner's spouse, for example—the other witness may be such home's owner, operator, or employee. See *id.* at § 3(b)(3); § 1(8). Thus, at least one (and possibly both) of the witnesses to a patient's request may have an interest in "freeing up the bed" for a paying resident.

³⁶ See *id.* at § 5(a).

³⁷ See *id.* at § 1(4).

to require an objective observer to the act. This is an open invitation to abuse since no one will know if the patient resisted.³⁸ R.B. 5326 compounds the problem since self-administration merely means that the patient ingested, that is, swallowed, the lethal drug,³⁹ blurring the line between assisted suicide and euthanasia. Further, R.B. 5326 requires that the attending physician, if completing the death certificate, lists the underlying condition as the cause of death.⁴⁰ Consequently, family members may never know that their loved one died from a lethal prescription.

The pre-bellum slave codes equated human beings with items of property, “reduced[ing] ... [slaves] to animals, or real estate, or even kitchen utensils[.]”⁴¹ Reflecting on this shocking phenomenon, Judge Noonan of the Ninth Circuit has observed: “law can operate as a kind of magic. All that is necessary is to permit legal legerdemain to create a mask obliterating the human person being dealt with. Looking at the mask ... is not to see the human reality on which the mask is imposed.”⁴²

R.B. 5326 calls itself “AN ACT CONCERNING COMPASSIONATE AID IN DYING[.]” It characterizes requests for and ingestion of lethal prescriptions in such terms. It categorically forbids all state agencies from referring to such practices as “suicide” or “assisted suicide,” requiring them to use the label “aid in dying” instead.⁴³ It even calls for falsification of the death certificate to list the patient’s underlying condition rather than the ingestion of lethal drugs as the cause of death.⁴⁴

Like the slave codes, R.B. 5326 operates as a kind of magic. By offering safeguards that serve instead to place patients at risk of abuse, it employs legal slight-of-hand. By calling “aid in dying” practices that simply help patients make themselves dead, it recites empty incantations. By not affirming patients’ lives but rather abandoning them to their despair, it creates only an illusion of compassion. True compassion, however, “leads to sharing another’s pain; it does not kill the person whose pain we cannot bear.”⁴⁵ The plain fact is that R.B. 5326 will legalize assisted suicide, and no legal magic can mask that reality. I urge the Committee to reject this dangerous and deceptive bill.

³⁸ See generally, Margaret K. Dore, *Physician-Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice*, 36-WTR Vt. B.J. 53 (2011).

³⁹ See R.B. 5326, §1 (18).

⁴⁰ See *id.* at §9(b). Moreover, since records concerning patients’ requests for lethal prescriptions are only subject to legal process in order to “resolve matters concerning compliance with [R.B. 5326,]” *id.* at §11, families are faced with a “Catch 22” since they must know their loved ones died from a lethal prescription rather than natural causes before they can review the records to determine whether a request for such prescription was made.

⁴¹ John T. Noonan, *The Root and Branch of Roe v. Wade*, 63 NEB. L. REV. 668, 669 (1984).

⁴² *Id.*

⁴³ R.B. 5326, 16(c). The Raised Bill further forbids such practices from constituting “suicide for any purpose[.]” *id.* at 13(d)(4), or “Causing or assisting another person to commit suicide.” *Id.* at 15(b).

⁴⁴ See *supra* note 40.

⁴⁵ Pope John Paul II, *Evangelium Vitae* [Encyclical Letter on the Gospel of Life] ¶ 66 (1995).

